

Provider Manual

Section 2.0

Administrative Procedures

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2.0 Administrative Procedures

2.1 Eligibility

Most individuals who meet the Department for Medicaid Services (DMS) eligibility criteria for Medicaid and reside in the Plan's service area are assigned to Passport Health Plan, and include individuals in the following categories:

- Temporary Assistance to Needy Families (TANF).
- Child and family related medical cases (KTAP).
- Aged, blind, and disabled (Medicaid only).
- Pass through.
- Pregnant women and children, SOBRA (Sixth Omnibus Budget Reconciliation Act), including presumptive eligibility.
- State supplementation for aged, blind, and disabled.
- Supplemental Security Income (SSI).
- Younger than 21 years and in a psychiatric residential treatment facility (PRTF).
- Younger than 18 years, placed in foster care and under supervision of a Kentucky public or private child welfare agency.
- Children younger than 18 who are adopted and have special needs.
- Kentucky Children's Health Insurance Program (KCHIP).
- Receiving noninstitutional hospice services.

DMS does not allow certain categories of Medicaid members to participate in managed care. Individuals in the following categories are not eligible for Passport Health Plan:

- Individuals who must spend down to meet eligibility income criteria.
- Individuals currently Medicaid-eligible who have been in a nursing facility for more than 31 days (Passport Health Plan is responsible for professional services until member is disenrolled by DMS).
- Individuals determined eligible for Medicaid because of a nursing facility admission.
- Individuals served under the alternative intermediate services, mental retardation, or developmental disabilities (AIS-MR-DD), home and community-based, or other Medicaid waivers.
- Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualified Disabled Working Individuals (QDWIs).
- Individuals in an intermediate care facility for the mentally retarded (ICF-MR).
- Individuals in a psychiatric facility, excluding a PRTF.

If you have any questions regarding eligibility criteria, contact Provider Services at (800) 578-0775.

2.2 Passport Health Plan Enrollment

The Department for Medicaid Services automatically assigns eligible members to Passport Health Plan. Once enrolled, a member receives a welcome kit from Passport Health Plan, which includes a PCP and Direct Access Directory, a Health Risk Assessment (HRA), and a Member Handbook.

2.3 Choosing a Primary Care Provider (PCP)

The Plan believes primary care providers (PCP) help ensure access to necessary health care and continuity and coordination of care. Within 10 days of enrollment, all members are provided with information regarding the selection of a participating PCP. Members may contact Member Services for assistance in selecting a PCP. If a member (except SSI members) does not select a PCP within 30 days, a PCP is assigned to the member based on the following:

- The member's previous PCP selection, when applicable.
- Current family PCP selection(s), when applicable.
- Geographic location.

Once the selection or assignment has been made, a Passport Health Plan member identification card (ID) with the PCP group's name and office telephone number is mailed to the member.

PCPs include physicians (medical doctors and doctors of osteopathy) or groups (including federally qualified health centers, rural health centers, primary care centers) in the following specialties:

- Internal medicine.
- Pediatrics.
- Family practice.
- General practice.
- Obstetricians/Gynecologists.

PCPs may also include:

- Advanced registered nurse practitioners who have entered into a collaborative agreement with a participating PCP; and,
- Physician assistants who have entered into a practice agreement with a participating PCP.

Each individual family member enrolled in the Plan must choose a PCP, except children living in out-of-home placement (see Section 12.3) and Medicare Primary eligible members (see Section 5.5). Each family member may choose a different PCP.

2.4 Identification Cards

Passport Health Plan issues a plastic identification card for each family member enrolled. Members are advised to keep the ID card with them at all times.



ID cards contain the following information:

- Member’s name.
- PCP group name and telephone number.
- Passport Health Plan coverage effective date.
- Passport Health Plan identification number.
- State identification number.

Besides the Passport Health Plan ID card, each member is issued a Medicaid ID card by the Department for Medicaid Services (DMS). The Medicaid ID card is NOT the same as the Passport Health Plan ID card:



The Kentucky Medicaid ID card represents eligibility for the Medicaid Program and is also used to obtain Medicaid covered services that are not covered through Passport Health Plan, such as services from behavioral health providers. Members are requested to keep and present their Kentucky Medicaid ID card along with their Passport Health Plan ID card.

2.4.1 Member Identification and Eligibility Verification

Passport Health Plan member eligibility varies by month. Therefore, each participating provider is responsible for verifying member eligibility with Passport Health Plan before providing services. Eligibility can be verified by:

- PCPs only - checking the practice’s Passport Health Plan panel roster (a comprehensive list of Passport Health Plan members assigned to the practice) for each visit. Please be certain to check not only the member’s name on the panel roster report but also his or her effective date.

- Visiting the Provider Center of the Plan’s web site, www.passporthealthplan.com, or by calling the IVR or Provider Services at (800) 578-0775.
- Utilizing the Plan’s real-time member eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system eligibility verification, including point of service (POS) devices.
- Asking to see the member’s Passport Health Plan ID card and Kentucky Medicaid ID card. **Please note that Passport Health Plan cards are not returned to the Plan when a member becomes ineligible.** Therefore, the presentation of a Passport Health Plan ID card is not sole proof that a person is currently enrolled in the Plan.

Providers should request a picture ID to verify that the person presenting is indeed the person named on the ID card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. If you suspect a noneligible person is using a member’s ID card, please report the occurrence to Passport Health Plan’s Fraud and Abuse Hotline at (866) 833-9718 or the KyHealth Choices Medicaid Fraud Hotline at (800) 372-2970.

2.5 Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that may be contrary to the provider’s conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact Provider Services at (800) 578-0775. A Provider Services representative will work with the provider to review the member’s needs and transfer or refer the member to another appropriately qualified provider for care.

2.6 Health Education and Special Programs

Passport Health Plan may refer members to health education classes provided by health agencies and providers. Providers who identify members who could benefit from education for a specific condition, such as pregnancy, asthma, or diabetes may call (800) 578-0603 for class information and schedules. Members also have access to over 1,200 health topics through an audio library. A member may call the 24-Hour Nurse Advice Line to access the audio library (see Section 2.6.3).

2.6.1 Language Assistance for Members

Federal law requires providers to ensure that communications are effective. Providers of health services, medical services, or social service programs to Passport Health Plan members indirectly benefit from a program that receives federal financial assistance and are, therefore, subject to the requirements of Title VI of the Civil Rights Act of 1964. This act prohibits recipients of benefits from a program receiving federal financial assistance, such as Medicaid, from being excluded on the grounds of race, color, or national origin. The term “on the grounds of national origin” has been interpreted to include persons with limited-English proficiency (LEP).

This law requires every Medicaid provider, including Passport Health Plan providers, to provide every member with LEP equal access to benefits and services by ensuring that each LEP person can communicate effectively in his or her language of choice. This law also requires providers to take

reasonable steps to provide language assistance at no cost to Passport Health Plan members with LEP.

Providers may contact the Plan's Cultural & Linguistics Services Program at (502) 585-7932 for additional information and/or questions.

2.6.2 Help for Those with Impaired Vision or Hearing

The Member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, the Plan's TDD/TTY number for Member Services is (800) 691-5566.

2.6.3 24-Hour Nurse Advice Line and Audio Library

Members may talk with a nurse 24 hours a day, 7 days a week by calling the 24-Hour Nurse Advice Line at (800) 606-9880. Through the same number, members may access an audio library of over 35 categories of health care topics, including (but not limited to):

- Cancer
- Women's Health
- First Aid
- Allergies and Asthma
- Disease and Injury Prevention

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, the TDD/TTY number for the Nurse Advice Line is (800) 648-6056.

NOTE: The 24-Hour Nurse Advice Line is not meant to take the place of the PCP and may not be used for after-hour coverage.

2.7 Marketing Rules

Passport Health Plan's contract with DMS defines how the Plan and its providers market and advertise the Plan. Accordingly, providers must adhere to the following graphic standards:

Plan Name:

- The name of the Plan may only be referenced, in print and audio, as Passport Health Plan. Other deviations of this name are not permitted (PHP, Passport, etc).
- The name, Passport Health Plan, may only appear in black and only in Adobe Garamond or Arial fonts.
- The name, Passport Health Plan, may not be animated or graphically altered in any way for television, print, or web-based advertising.

Logos:

- The Passport Health Plan logo may not be used. This means the Passport Health Plan logo may not be copied, scanned, downloaded, animated, replicated, or modified for print or used as a graphic element as part of a television or web-based advertisement.

Tag Lines:

- No past, present, or future tag lines of the Plan may be utilized in any provider advertising.

Copy:

The following copy may be used to indicate a provider's affiliation or participation in the Plan:

Acceptable references to the Plan include:

- We accept Passport Health Plan and The Kentucky Children's Health Insurance Program (KCHIP) members.
- We accept Passport Health Plan and The Kentucky Children's Health Insurance Program (KCHIP) cards.
- We welcome Passport Health Plan and The Kentucky Children's Health Insurance Program (KCHIP) members.

Unacceptable references include:

- References to Passport Health Plan benefits and co-pays
- Statements that indicate services are guaranteed by Passport Health Plan
- Statements that indicate that eligibility is determined by the Plan

Images:

- Images or duplications of the Passport Health Plan member ID card may not be used in any advertisements
- Images of actual Passport Health Plan members or associates

KyHealth Choices/Kentucky Department for Medicaid Services*

KyHealth Choices/Kentucky Department for Medicaid Services

- The use of the name KyHealth Choices or the words, Medicaid, DMS, or the Kentucky Department for Medicaid Services will be approved or disapproved at the discretion of the Kentucky Department for Medicaid Services.

* In addition to these graphic standards, The Kentucky Department for Medicaid Services, along with Passport Health Plan, will review and approve or disapprove all proposed and/or existing advertising related to providers promoting their participation and/or affiliation with Passport Health Plan.

Questions or comments about the Passport Health Plan Provider Advertising Graphic Standards should be directed to:

Director, Public Affairs
Passport Health Plan
Phone: (502) 585-7331, or 1-800-578-0603, ext. 77331

2.8 Provider Terminations/Changes in Provider Information

2.8.1 Provider Terminations

Termination of an existing PHP contract requires ninety (90) days written notice. A provider desiring to terminate his/her participation must submit a written termination notice, including the final termination date, to his/her assigned Provider Relations representative within the applicable notice period as outlined in the provider agreement.

Should a single specialist or an entire specialty group decide that it wishes to terminate its contract, a list of members on the specialist's panel receiving ongoing health care must be sent to the Plan no less than 60 days for member notification to occur. The specialist's Provider Relations representative will work with the specialist to ensure a smooth transition for the member's continued care.

2.8.2 Changes in Provider and Demographic Information

Providers are required to notify 90 days in advance both Passport Health Plan's Provider Relations department and the Department for Medicaid Services in writing of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions/deletions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.

Reimbursement may be affected if changes are not reported in accordance with Plan policy.

2.8.3 Change in Location

Should a provider working in multiple offices discontinue working in one location, please be clear in communication to the Plan as to where employment is terminating as well as the specific offices where employment is continuing.

2.8.4 Panel Closings

Passport Health Plan recognizes that PCPs may occasionally need to limit the number of patients in their practices in order to deliver quality care. The Plan requires a minimum of 50 members per practitioner panel. (For additional information regarding member to practitioner ratios, see Section 4.3.)

Once a PCP has accepted the number of Passport Health Plan members agreed upon in the Primary Care Provider Agreement, a written request must be forwarded to the Plan to limit or stop assignment of members to the panel. Please send your request to your Providers Relations representative at 305 W. Broadway, 3rd Floor, Louisville, KY 40202.

The Plan prefers 90 days advance written request to change panel status.

2.8.5 Panel Limitations

Panel limitations and/or removal of panel restrictions must be submitted in writing to the Provider Relations representative. Providers are notified by their Provider Relations representative of the approval or denial of the request. Approved panel limitations and/or removal of restrictions become effective at the beginning of the month following the month the changes were approved by the Plan.

2.8.6 Member Dismissals from PCP Practices

Primary care providers (PCP) have the right to request a member's disenrollment from their practice and request the member be reassigned to a new PCP for the following circumstances:

- Incompatibility of the PCP/patient relationship;
- Inability to meet the medical needs of the member.

PCPs do not have the right to request a member's disenrollment from their practice in the following situations:

- A change in the member's health status or need for treatment.
- The member's utilization of medical services.
- A member's diminished mental capacity.
- A member's disruptive behavior that results from the member's special health care needs unless the behavior impairs the PCP's ability to provide services to the member or others.

Disenrollment requests shall not be based on the grounds of race, color, national origin, handicap, age or gender.

Disenrollment requests must be submitted to the Plan and sent via fax to Provider Services at (215) 937-5304. Requests must include provider name, provider group ID number, member name, member ID number, reason for disenrollment request, and effective date. Members are not disenrolled from the PCP's practice until all required information is received.

Disenrollment requests meeting the Plan's requirements as stated above are reviewed, determined to be appropriate, and processed within five business days by Provider Services. The disenrollment effective date must be no less than 30 days to allow for the member's transition to a new PCP unless extenuating circumstances necessitate an immediate effective date.

The initial PCP must continue to serve the member until the new PCP assignment becomes effective, barring ethical or legal issues. The member has the right to appeal such a transfer via the Plan's formal appeal process.

If a PCP's request does not meet the above stated requirements, the appropriate Provider Relations representative will contact the PCP directly to discuss.

Please note this process does not apply to "age-out" disenrollments for pediatric practices.

2.8.7 Locum Tenens

According to PHP policy, participating Plan providers may utilize the services of a locum tenens provider, under temporary circumstances, for a period of sixty (60) consecutive days or less. When locum tenens are required, participating PHP providers must register the substitute provider. This process must be completed prior to the provision of any services by a locum tenens provider.

To register a locum tenens provider, the participating PHP provider must complete a one-page *Registration of Locum Tenens Physician* form (available in Section 19 of this *Provider Manual*). Both the participating PHP provider and the locum tenens provider must sign the form. To complete the registration process, the signed form must be returned to the Plan by mail or by fax at:

Mail:

Passport Health Plan
Attn: Contracting Department
305 W. Broadway
Louisville, Kentucky 40202

Fax:

Attn: Contracting Department
(502) 585-8280

Services rendered by a locum tenens provider must be billed utilizing the absent provider's Plan ID number and the Q6 modifier with the applicable procedure code(s). The Q6 modifier signifies that the service was provided by a locum tenens provider. According to the PHP provider agreement, the absent provider remains liable and all contractual terms remain effective throughout the employ of a locum tenens provider.

If services by a locum tenens provider remain necessary beyond the period of sixty (60) consecutive days, the locum tenens or substitute provider must apply for participation with PHP and complete the credentialing process and have or apply for a Kentucky Medicaid number. Upon becoming credentialed with the Plan, the provider will be assigned a provider ID number for billing purposes.

2.9 Members' Rights

Members are informed of their rights and responsibilities through the Member Handbook. Passport Health Plan providers are also expected to respect and honor members' rights.

Passport Health Plan members have the following rights:

- To receive information about Passport Health Plan, its benefits, services and providers, and their rights and responsibilities.
- To be treated with respect and have recognized their dignity and the right to privacy and nondiscrimination as required by law.
- To participate with their providers in making decisions regarding their health care.
- To discuss treatment options, regardless of cost or benefit coverage.
- To voice grievances or file appeals about Passport Health Plan decisions that affect their privacy, benefits, or the care provided.
- To expect their medical records and care to be kept confidential, as required by law.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To privacy of their health care needs and information, as required by law.

- To allow or refuse their personal information be sent to another party for uses such as data used in research studies, workers compensation claims, and outside marketing purposes, except when the release of information is required by law.
- To choose a primary care provider (PCP) and to change to another PCP.
- To receive timely access to care, including referrals to specialists when medically necessary, without barriers.
- To look at and get a copy of their medical records, as required by law.
- To file for a State Hearing with the Department for Medicaid Services at anytime.
- To receive materials in alternative formats and other languages if necessary.
- To make an advance directive, such as a living will.
- To choose a person to represent them for the use of their information by Passport Health Plan if they are unable to.
- To make suggestions about their rights and responsibilities.

Passport Health Plan members have the following responsibilities:

- To take all their ID cards (Passport Health Plan ID card, Kentucky Medicaid ID card, and any other insurance card) to all medical appointments.
- To follow the policies and procedures of the Department for Medicaid Services and Passport Health Plan.
- To provide, to the best of their ability, information that Passport Health Plan and providers need in order to care for them.
- To follow the instructions and plans of care they have agreed to with their provider.
- To learn about their rights.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their primary care provider (PCP).
- To obtain a referral from their primary care provider (PCP) before seeing a specialist.
- To ask their provider questions about the care they receive.
- To ask their provider questions about his or her instructions.
- To understand their health problems and work with their provider as much as possible to decide treatment goals that both agree on.
- To follow the steps of the appeal process.
- To make good decisions about their health and things that affect their health.
- To notify Passport Health Plan if they suspect fraud or misuse of Passport Health Plan ID cards or benefits by a member or provider.
- To notify the Department for Community Based Services (DCBS), Passport Health Plan, and their providers of any changes that may affect their membership, health care needs, or access to benefits. Some examples may include:
 - If they have a baby.
 - If their address changes.
 - If their telephone number changes.
 - If they or one of their children are covered by another health plan.
 - If they have a special medical concern.
 - If their family size changes.

- To keep appointments with providers and call to cancel appointments when they cannot be there.

2.10 Member Appeals

For provider appeals, please refer to Section 6.11.

All members have the right to appeal any action by Passport Health Plan. An appeal is a request for review of an action or a decision by Passport Health Plan related to covered services or services provided. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act within specified timeframes; or a denial of a request to obtain services outside the network for specific reasons.

Member appeals can be filed orally, in writing, or in person. An oral filing must be followed by a written, signed appeal. At no time will a member be discriminated against because he or she has filed an appeal. We always respect our members' privacy. Anything they say or write is kept confidential. There are two types of member appeals that may be directed to the Passport Health Plan appeals coordinator:

1. A pre-service medical-necessity denial appeal
2. A benefit denial appeal

An expedited review process is available for a member pre-service medical-necessity appeal when the Plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; health; or ability to attain, maintain, or regain maximum function (see Section 2.10.2.).

Please address all pre-service medical-necessity and benefit appeals to:

Passport Health Plan
Attn: Appeals Coordinator
305 W Broadway, 3rd Floor
Louisville, KY 40202

2.10.1 Member Pre-service Medical-Necessity Appeals

A pre-service appeal is a request for review of an action by Passport Health Plan related to requested services not yet received by the member. The member, an authorized representative of the member, or a provider acting on behalf of the member may file a pre-service appeal.

Appeals filed by the provider on the member's behalf require the member's written consent. **If the member's written consent is not received within 30 calendar days of the action then no appeal will be initiated.**

The appeal must be filed in writing, and the Plan must receive it within 30 calendar days from the date of a notice of an action by the Plan. A 14 calendar-day extension will be granted at the

member's request. The Plan can also request a 14 calendar-day extension if there is a need for additional information and the delay is in the member's best interest.

Within three business days of receipt of the written appeal, the Plan will send the member a letter acknowledging receipt of the appeal and advising of the date the appeal will be heard. The member may present supporting documentation or evidence in person or in writing on or before that date. A board-certified physician with clinical expertise in treating the member's condition or disease who was not involved in the initial denial reviews all member pre-service medical appeals. The Plan will communicate to the member and the provider an appeal decision within 30 calendar days from the Plan's receipt of the appeal.

The appeal decision is final, and at this point, the member has exhausted all appeal options with Passport Health Plan. However, the Plan's appeal process does not have to be exhausted for the member to request a State Hearing (see Section 2.10.4). The member may request a State Hearing through the Department for Medicaid Services within 30 calendar days from the date of Passport Health Plan's last decision notification. The member may also contact Kentucky's Ombudsman for assistance at any time during the appeal process. Members may call Passport Health Plan Member Services at (800) 578-0603 for help filing a medical appeal.

If the member is currently receiving authorized services that are now denied and the member wishes to continue to get these services, he or she must request an appeal in writing within 10 days of the denial letter. The request must clearly state that the member wishes to continue getting the services. Services may be continued until the appeal decision is made. If, however, the appeal decision agrees with Passport Health Plan's denial, the member may have to pay for the services.

2.10.2 Member Expedited Appeals

If the member's appeal is about care that is medically necessary and needed soon, a Passport Health Plan Medical Director other than the Medical Director rendering the original denial decision, will review the appeal on an expedited basis. An expedited review process is available for a member appeal that is for pre-service medical necessity. This expedited review process may take place when the Plan determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The Plan communicates an appeal decision to the member within 72 hours.

2.10.3 Member Administrative/Benefit Appeals

Member administrative/benefit appeals include, but are not limited to, appeals for requested services and appeals for removal from the lock-in program. The member, an authorized representative of the member, or a provider acting on behalf of the member may file a member administrative/benefit appeal.

Appeals filed by the provider on the member's behalf require the member's written consent. If the member's written consent is not received within 30 calendar days of the action then no appeal will be initiated.

The appeal must be filed in writing, and the Plan must receive it within 30 calendar days of the date of notice of an action by the Plan. A 14-calendar day extension will be granted at the member's request. Within three calendar days of receipt of the written appeal, the Plan will send a letter to the member acknowledging receipt of the appeal and advising of the date the appeal will be heard. The member may present supporting documentation or evidence in person or in writing on or before the date that the appeal is to be heard. The Administrative/Benefit Appeals Committee reviews all administrative/benefit denial appeals. The Plan will communicate to the member an appeal decision within 30 calendar days of receipt of the appeal.

The appeal decision is final, and at this point, the member has exhausted all appeal options with Passport Health Plan.

2.10.4 State Resources Available to Members

As previously stated, the Plan's appeal process does not have to be exhausted for the member to request a State Hearing. The member may request a State Hearing through the Department for Medicaid Services within 30 calendar days from the date of the last decision notification by the Plan. Passport Health Plan will cooperate with any decision the State makes. The member may also contact Kentucky's Ombudsman for assistance at any time during the appeal process. Members may call Passport Health Plan Member Services at (800) 578-0603 for help filing a medical appeal.

Members may contact the Kentucky Ombudsman at any time at the following address:

Cabinet for Health Services
Office of Ombudsman
275 East Main St., 1E-B
Frankfort, KY 40601
(800) 372-2973
TDD/TTY (800) 627-4702

Passport Health Plan will cooperate with any State decision. A member may send a request for a State Hearing to the following address:

Kentucky Department for Medicaid Services
Division of Administration and Financial Management
275 East Main St., 6W-C
Frankfort, KY 40601
(800) 635-2570
TDD/TTY (800) 775-0296